DEPARTMENT OF HEALTH AND HUMAN SERVICES OTC 10/7/10
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	C 08/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigations numbers TN25131, TN25988, TN26563, and TN26579, were conducted August 18 to August 23, 2010, and a deficiency was cited related to complaint number TN25988, under 42 CFR Part 482.13, Requirements for Long Term Care.	F 000		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews, policy reviews, and interviews, the facility failed to maintain complete and accurate medical records for one (#3) resident of six residents reviewed. The findings included: Review of a closed medical record revealed resident #3 was admitted to the facility on January 8, 2010, with diagnoses including Cerebrovascular Accident, Urinary Tract Infection, Benign Prostatic Hypertrophy, and Atonic	F 514		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	9-08-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	C 08/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 1 Bladder, and was discharged from the facility on January 26, 2010. Review of a physician's order dated January 9, 2010 revealed, "May do in and out cath Q (every) shift d/t (due to) atonic bladder". Review of the treatment record and intake/output record revealed resident #3 was catheterized during the day shift on January 15 and January 21, 2010, without the amount of urine obtained documented. Further review of the treatment record and intake/output record revealed the resident was catheterized on the night shift on January 15, 17, 20, and 25, 2010, without the amount of urine obtained documented. Review of the intake/output record for resident #3, revealed a handwritten note at the top of the record which stated, "Pls (please) record urine output from in and out cath Q shift". Review of the facility's catheterization policy revealed a "Catheterization for Residual" policy which stated, "Chart time, observations, amount voided, and obtained by catheter". Interview with the Director of Nurses (DON) on August 23, 2010, at 4:00 p.m. at the A/B wing nurse's station, confirmed resident #3's urine residual amounts should have been documented after being catheterized, but had not been. Review of physician's orders revealed an order dated January 8, 2010, for Accuchecks (blood sugar levels), and sliding scale insulin doses before meals and at bedtime. Review of nurses notes, medication records, treatment records, and chemstick records revealed no documentation of the accucheck results before breakfast on January 19, 2010, or the sliding scale dosage of insulin for 6:00 am or 11:00 am on that same day.	F 514	The DON in-serviced the identified staff members on missing documentation for I/Os and Accuchecks . (In-services attached) An in-service on documentation , charting guidelines and introduction of new audit form will be accomplished for all licensed staff, including prn, by September 24, 2010 (inservice content attached) To identify other residents who could be affected, the A/C lead nurse and the Skilled charge nurse began daily audits on 9-03-10 for accuchecks, and I/O s, using thedaily 24 hour report. A new audit form will be used beginning September 9. The skilled charge nurse will audit B wing patients; The A/C lead nurse will auditA and C Wing patients. This will be done daily for 6 weeks, then weekly thereafter. The QA nurse will audit behind the lead nurses weekly to assure the audits are identifying any deficient practices. The QA nurse will report any non-compliance to the Director of Nursing. The Director of Nursing will use employee re-education and progressive disciplinary action when trends are identified. The QA team, consisting of the administrator, director of nursing, medical director, pharmacist, social worker and other department managers, will oversee the ongoing documentation audit process.	09-01-10 09-24-10 09-03-10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445235	A. BUILDING _____ B. WING _____	C 08/23/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULEVARD TERRACE NURSING HOME	1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 2 Further review of the Chemstick Record revealed the blood sugar at 11:00 am, on January 19, 2010, was "134" which required 2 units of Novolog Insulin. Further review of the nurse's notes, medication record, and Chemstick Record, revealed no documentation of the insulin being administered. Interview with Registered Nurse (RN) #1 by telephone on August 23, 2010, at 3:05 p.m., revealed RN #1 was responsible for performing the accuchecks and administering the sliding scale insulin to resident #3 on January 19, 2010. RN #1 stated ...is certain the accucheck was performed and sliding scale insulin was administered as ordered, and that RN #1 had failed to document the information in the medical record. Review of the facility's policy titled "Insulin Administration" revealed "WBGs (Whole Blood Glucose levels) and Sliding Scale or scheduled insulin should be documented ...". Interview with the Director of Nurses (DON) on August 23, 2010, at 4:00 p.m. at the A/B wing nurse's station, confirmed the accucheck result at 6:00 a.m. and the sliding scale insulin dosages at 6:00 a.m. and 11:00 a.m., on January 19, 2010, had not been documented. C/O TN25988	F 514	The DON in-serviced the identified staff members on missing documentation for I/Os and Accuchecks . (In-services attached) 09-01-10 An in-service on documentation , charting guidelines and introduction of new audit form will be accomplished for all licensed staff, including prn, by September 24, 2010 09-24-10 (inservice content attached) To identify other residents who could be affected, the A/C lead nurse and the Skilled charge nurse began daily audits on 9-03-10 for accuchecks, and I/O s, using thedaily 24 hour report. A new audit form will be used beginning September 9. The skilled charge nurse will audit B wing patients; The A/C lead nurse will auditA and C Wing patients. This will be done daily for 6 weeks, then weekly thereafter. 09-03-10 The QA nurse will audit behind the lead nurses weekly to assure the audits are identifying any deficient practices. The QA nurse will report any non-compliance to the Director of Nursing. The Director of Nursing will use employee re-education and progressive disciplinary action when trends are identified. The QA team, consisting of the administrator, director of nursing, medical director, pharmacist, social worker and other department managers, will oversee the ongoing documentation audit process.	